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Capricode

Capital Projects Code

Hospital Building Procedure Notes

Planning Policies

Assessment of Functional Content

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Hospital Building Procedure Note No. 2

Planning Policies

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Hospital Building Procedure Note No. 3

Assessment of Functional Content

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Capricode

The National Health Service Capital Projects Code is intended to be a source of reference for all concerned with the planning of buildings in which to provide the health and welfare services which are the responsibility of the Secretary of State of the Department of Health and Social Security. Eventually it will contain all the procedural and financial guidance issued by the Department in relation to the building programmes for which it is responsible and will incorporate lists of the professional and technical guidance which is available in connection with the planning of particular buildings or departments of hospitals.

The first chapters of CAPRICODE take the form of a series of notes aimed at standardising the method of approach to the planning of hospital buildings. Hospital Building Procedure Note No. 3 (which should be read in conjunction with the other H.B.P. Notes) deals with the functional content of a hospital project which is closely linked with operational policies discussed in H.B.P.N.2.

By strict adherence to the procedures described maximum use of both manpower and capital resources will be achieved and the delays which have been occasioned in the past by reason of omission or inadequate costing will be avoided. If the procedures are followed faithfully approval will be given much more speedily than has hitherto been possible, even on multi-million pound projects of such a complex nature. This chapter of CAPRICODE is accordingly commended to hospital authorities and they are urged to ensure that all who are concerned with them in the provision of hospital buildings are aware of the guidance and of its importance in the context of the work which they do.

Planning Policies

Scope

1 This note describes the purpose, content and method of presentation of the various policy statements which are needed in the formulation and development of hospital planning proposals.

2 The relationship of the policy statements to the Stages of the building procedure is discussed, particularly in relation to the statement of functional content (see Hospital Building Procedure Note No. 3).

Definitions

3 **Policies** are defined (for the purpose of this note) as the application of general principles to specific situations. The situation may range from regional decisions on location of hospitals to the detailed planning of departments in a particular hospital.

4 Policies will thus reflect general planning principles laid down at Regional Board level, and describe their application in the light of the local requirements and limitations bearing upon a specific project. Policies may refer to various aspects of planning, the main division being between operational policies and design policies. The former relates to staffing, organisation and function, while the latter applies to layout, environment and construction.

Objectives

5 The primary objective in formulating a statement of policy is to determine for the project the pattern of organisation and design which will provide optimum service with the available resources of staff and finance.

6 The secondary objective is to communicate that pattern in terms which will:

(a) enable the architect and engineer to design an efficient and economical building in which this organisation can function;

(b) enable staffing requirements and revenue consequences to be assessed;

(c) permit co-ordination of the functions of individual departments both within the hospital and with medical services outside the hospital *before* the building and engineering content has been finalised.

7 Since the statement of operational policy is a communication to the ultimate users as well as the designers of the project, the reasoning behind the decisions expressed in the policy statement should briefly be recorded for use in subsequent commissioning, staff training and evaluation.

General description of types of policy statement

8 Four types of policy statement are needed:

(a) Regional planning principles;

(b) Regional (standard) policies;

The content of these documents will be the various planning principles and policies (whether operational or design) which the Board wishes to see applied to all or most of the building projects undertaken by it. The statements thus describe the Board's philosophy and basic approach to the planning, organisation and design of its new hospital buildings.

(c) outline project policy;

This statement will indicate the extent to which the statements at (a) and (b) above are to be modified or amplified in relation to the circumstances of the individual project. It will be initially produced by the Planning Group and put into complete form, as a result of any consultations which may be necessary, by the Project Team directly responsible for the planning and design of the project in the light of the Team's knowledge of the local factors affecting it.

(d) detailed project policy;

This statement will be prepared by the Project Team itself. Its content will be founded on the instructions given in the documents at (a), (b) and (c) above and will be organised essentially in two parts: those policies, whether operational or design, which relate to the whole hospital, or the complex of departments regarded as a complete organisation; and the operational policies related to individual departments or services. The first part will be required for the purposes of Stage B2 of the building procedure, the second part must be brought to conclusion in the early part of Stage C.

Regional planning principles

9 The statement of planning principles and the statement of (standard) policies can conveniently be contained in a single document, arranged so that amendment or replacement of individual paragraphs is easy. The document should be prepared under the supervision of the Planning Group, not necessarily in relation to any individual building project, but rather in order to provide a policy foundation for all building projects to be undertaken by the Board. The initial version of the document will necessarily simply be a record of planning principles and standard policies hitherto adopted and applied by the Board, but as experience emerges from the planning and design of individual projects, from research and development activity, and from changes in medical, nursing and design practice, the document will have to

be modified and amended. The aim should be to keep it amended in the light of the factors listed above so that an up-to-date version of it can be handed to any individual Project Team at Stage A1 of the planning procedure for the project with which the team is concerned. It will thus form an essential part of the briefing to the Team at the inception of the project.

10 The statement of planning principles comprises an outline of the organisational and design principles covering the requirements at Stages A and B of the hospital building procedure. As such it will contain information reflecting the Board's philosophy in relation to:

(a) **Factors affecting projects as a whole (whole hospital policies)**

This section will outline the Board's policy in regard to such matters as

(i) basis for assessment of functional content in relation to existing and projected hospital service provision in the locality;

(ii) methods and nature of consultation with other authorities e.g., local health authorities, hospital management committees, planning authorities etc;

(iii) principles by which the Team should be guided in producing solutions to such whole hospital organisational problems as arise on supply services, car parking, provision of residential accommodation, centralisation of laundry and C.S.S.D. services, etc;

(iv) any general principles in regard to patient service which the Board wishes to see observed uniformly throughout its projects e.g., in relation to the adoption of progressive patient care, the location of child patients in paediatric departments, the extent and nature of psychiatric provision to be made at general hospitals, the extent of use of day hospitals, the arrangements for the association of general practitioners with the hospital's functioning, etc;

(v) Design principles affecting the hospital as a whole, e.g., in relation to building shapes, size of ward floors, interrelationship of departments, plot ratio and other planning considerations, etc;

(vi) The Board's policy in relation to detailed design e.g., the extent of use of industrialised building components, the extent of use of standardised departmental design material, dimensional disciplines, etc;

(vii) Board policy on such contractual aspects as the basis for the engagement of private design consultants, approved methods of preparing to tender, references to diverse material covering the selection of contractors and the award of contracts, references to regulations governing the control of variations and preparation of final accounts and such similar matters as govern the relationship between the Board as client and its consultants and contractors.

(b) **Basic information regarding each service or department of a hospital in the following terms**

(i) scope or function;

(ii) any indication of accommodation, including gross areas and costs, which the Board wishes to give as general guidance to all its Project Teams;

(iii) the relationship of the individual services or departments to one another;

(iv) supporting services;

(v) approach to the establishment of staff requirements;

(vi) guidance on the assessment of other revenue consequences;

(vii) design principles.

Regional (Standard) Policies

11 This document will be in effect a compendium, covering all hospital departments, of Board policy statements describing, for the purposes of planning, design and commissioning, aspects of the function, organisation, staffing, design, structure, engineering, maintenance and capital and revenue costs in sufficient detail so as to provide an authoritative basis for the detailed planning which occurs at Stage C of the hospital building procedure and subsequently. It will set out in some detail the standards in respect of all these matters which the Board wishes its Project Teams to observe, although the statement should make sufficient allowance for justifiable local variations in practice. The underlying principles should be to effect standardisation over as wide a range of operational and design material as possible to ensure the successful achievement of a large scale building programme. The degree to which absolute standardisation can be reflected in actual buildings will be influenced by local considerations.

12 Initially, the main source for Board standard departmental policies will doubtless be the Building Note series and similar documents (e.g. Design Notes) supplemented by the Board's own experience in the design and operation of individual departments. In time, however, the production by the Department of Health and Social Security of dossiers of standardised material on individual departments, the results of comprehensive design in use studies, and the fruits of research and development work on the organisation and design of individual departments, mounted either by Boards or by the Department, will provide material whereby standard policy statements can be amended and modified in the light of increasing knowledge and experience.

Outline project policy

13 Working from the statement provided by the Planning Group of the planning principles and standard policies to be observed as modified in relation to the individual project (see paragraph 8 [c]), the Project Team will, as part of its work in the preparation of the statement of functional content required at Stage A1, necessarily check and adjust the outline project policy statement so as to indicate the reasoning which has led it to the conclusions reflected in its statement of functional content.

14 To the extent that the Project Team has conformed to the planning principles and standard policies, the outline project policy statement will consist only of appropriate references to these controlling documents. But where, due to local considerations, it seems desirable to depart to any degree from the regional policies, then the adjusted outline project policy statement would indicate the degree and reason for the departure.

Detailed project policy

15 This will be prepared by the Project Team itself—see paragraph 8(d).

Check lists

16 It will be found that much time can be saved if Project Teams can be provided with standard proforma check lists based on Regional principles and policies and specifying the options available on major issues. The check lists will also provide a useful method of introducing varying degrees of standardisation, or experimentation with particular aspects of planning and design, which individual Boards wish to determine for themselves. If important omissions are to be avoided the compilation of these check lists should be done under the supervision of the Planning Group, on the basis of contributions from all the professions concerned in the planning process and Project Teams should feel free to suggest additions and amendments to the lists in the light of their use.

17 If this device is adopted, the check list, after it has been processed by the Project Team, will itself be in effect the outline project policy, thus ensuring from the start that a great deal of the detailed information which the architect and engineer need for the design of the project will be available with a minimum of time spent in consultation.

Format of policy statements

18 If a uniform method of presentation of policy statements can be adopted by all Boards, the time spent in the preparation and subsequent amendment of statements based on this format will be much reduced. A suggested format is given in the Appendix to this Note.

19 Because of unavoidable (and to a degree highly desirable) variation in policies as between one Board and another, it is impracticable for the Department to recommend standard policies relating to all the aspects of hospital planning, design and organisation. Nevertheless, a reasonable degree of uniformity in operational and design policies over the country is a desirable end in itself. Its attainment will be facilitated by the use of the standard format referred to above, and by the production, now in hand, by the Department of Health and Social Security of dossiers of standard operational and design material on individual hospital departments. No doubt, also, the interchange between Boards of policy statements of the types described above may lead to the adoption by some Boards of policies formulated by others. Eventually, therefore, a stage will be reached in which an acceptable degree of uniformity is reached over a wide area of the planning and design process, leaving unstandardised those aspects upon which further experimentation, research and development is required.

20 Since the object of the building procedure is to permit the Board and the Department to work together in the development and approval of individual hospital building projects, it is essential that the Department be provided with copies of all policy statements produced by individual Boards. Though the Department would feel free to comment on such aspects of the content of these statements which appear to warrant it, the main purpose of providing the material to the Department would be to ensure that in considering the proposals submitted to it in respect of an individual project, the Department is aware of the policy background against which the project has been formulated.

Suggested Format for Policy Statements

Note:

This list of contents would be used for all four statements. As transmitted by the Planning Group to the Project Team it would set out under each head the Board's Planning Principles and Standard Policies where they exist, annotated with any variations the Planning Group considers appropriate to the individual project. The material thus transmitted would then be modified by the Project Team during Stage A1, in the light of the factors affecting the individual project, so as to transform it into an Outline Project Policy statement for approval of the Planning Group. Thereafter, it would be gradually expanded and modified into the detailed Project Policy Statement (still retaining the same heads) as planning and design proceeds. It would thus become a comprehensive written statement of all the policies affecting a particular project and be available for commissioning, staff training, etc. in due course.

Section I—General

(i) Summarise layout of statement.

(ii) List of definitions.

(iii) List relevant references.

Section II—Policies Affecting Whole Hospitals or Complexes of Departments

(i) Principles upon which need (i.e. functional content) is to be assessed.

(ii) Board policies in regard to medical and nursing services and patient care.

(iii) Board policies in regard to organisation of supply and other services, or principles on which policies should be evolved by Project Team.

(iv) Methods to be used for consulting other authorities (e.g. other Boards, local health, planning authorities, H.M.Cs. etc.).

(v) Design Principles

- (a) siting and location,
- (b) layout, shape, height, (co-ordinated design framework),
- (c) space standards, (room data bank),
- (d) traffic circulation—internal, external, access,
- (e) environment and safety—light, ventilation, fire, security, infection, etc.,
- (f) service installations—water, gas, electricity, etc.,
- (g) use of industrial building technology,
- (h) contracting methods,
- (i) cost control methods.

Section III—Departmental Policies

Set out for each department and service

(i) Scope (i.e. functional content) and function,

(ii) department siting in relation to other departments, phasing, growth,

(iii) department layout, adaptability, grouping of working areas,

(iv) space standards for rooms and spaces,

(v) supporting or linked services,

(vi) environment and safety—special requirements for department,

(vii) equipment and services—special requirements for department,

(viii) appropriate selections from constructional data,*

(ix) staffing policy,

(x) assessment of revenue cost consequences.

*See the use of industrial building technology (C.U.B.I.T.H. programme) health service design notes.

Hospital Building Procedure Note No 3

Assessment of Functional Content

Hospital Building Procedure Note No. 3

Assessment of Functional Content

Scope

1 This note describes the way in which the functional content of a hospital project may be assessed at Stage A1. The connection between operational policies and functional content is very close and this note should therefore be read in conjunction with H.P.B.N.2.

Object

2 The object of assessing functional content is to decide:

(i) *what* shall be provided;

(ii) *when* it shall be provided;

(iii) *where* it shall be provided.

3 When the programme is drawn up these decisions are taken in outline for every project in it. At Stage A1 they are checked, altered if necessary and developed in greater detail. This note is about that stage but some of the methods described can also be used in drawing up a programme.

General Considerations

4 Because the relationship between the selection of operational policies and the assessment of functional content is very close, the statements of outline planning policies for a project and of functional content are normally presented together at the end of Stage A1 although their determination is described separately in this series of Hospital Building Procedure Notes.

5 Most planning solutions represent a choice between options. The Statement of Regional Planning Policies (see H.B.P.N.2) sets out some of the limits within which options might be selected; further limitations are imposed by the site(s) available, finance and staffing possibilities. These limitations need to be realistically appraised before the statement of functional content can be finalised.

The Task

6 The main task of the Project Team at Stage A1 is to present a statement of the project content which will enable the architect and engineer to make a feasibility study based on site considerations and general design concepts (Stages A2 and A3). The medical and nursing members of the team necessarily play the main parts in this but the team is, of course, collectively responsible for the statement.

7 While the Stage A1 statement of content should be regarded as definitive in most instances, there may be occasions when some adjustments are necessarily made at Stages A4—5 due to unforseen factors emerging in Stages A2—A3.

8 The need for precision in estimating functional content is proportional to the degree to which total requirement is being met. For example in a given project representing only 70 per cent of a group's net need, any marginal inaccuracy can be made good at the time of planning the remaining 30 per cent.

Determination of Planning Population

Catchment Area

9 The precise size of a hospital's catchment area, and hence population, is variable, most often in the order of 150,000 to 250,000 people. The catchment area may well be different for different specialities e.g. regional or sub-regional specialities serve a larger catchment area than do the more general functions of the hospital.

Age composition

10 When specifying the planning population it is necessary to consider not only the total but also the age composition as this may have significant influence on the provision to be made.

Vital statistics

11 Consideration must be given to local variations in the vital statistics as returned by the Local Authority and the Registrar General's office. Mortality and birth statistics may vary considerably as between different areas.

Population Projection

12 Account must be taken of population trends, including the assessed effect of migration, both natural and planned, for example, from an existing area to a new or expanded town.

Local Population 'drift'

13 It may also be necessary to consider local variations of demand due to such factors as housing development, transport facilities, seasonal influx at holiday centres, other hospital development.

Methods of Assessment

14 No entirely satisfactory method of assessing need has yet been arrived at, though for descriptive purposes two basic methods may be identified viz. the *empirical method* and the *analytical method.* Neither method can afford to ignore the fundamental difference between 'demand' and 'need'.

Demand and need

15 'Demand' for hospital services may be determined by taking the statistical returns of current usage and adjusting them in the light of morbidity statistics and waiting lists. It has been frequently observed that

demand is closely correlated with availability, and as such of little objective validity. The norms promulgated in Command 1604 are based upon national average demand.

16 Measurement of 'Need' for hospital services seeks to take a more positive approach to health by aiming at a quantitative estimation of the amount of illness in the community which should be treated in hospital.

17 Planning according to future need, as distinct from demand, should take into account that:

(a) much of the increase in treatment could be provided at an earlier stage of illness, and thus require a relative increase of out-patient facilities (an analogy is to be found in relation to conservative and radical dental treatment);

(b) improvement in facilities can only be economically provided—in terms of manpower as well as finance—if there is a close liaison between the various parts of the National Health Service.

EMPIRICAL METHOD

18 The empirical method is that which is in common use in this country. It consists in essence of applying a series of norms of provision (whether those promulgated in Command 1604 or alternatives accepted by the Board as more directly relevant to local conditions) to the population group to be served, together with various rules of thumb for departments which are not covered by these norms, and so arriving at a 'gross primary need' which is then locally adjusted as described below.

19 This method has the drawbacks inherent in any attempt to determine a precise solution to a specific problem by application of averages. The success of the application depends very largely on use of judgment in making the appropriate local adjustments.

ANALYTICAL METHOD

20 Under this method gross primary need, and to a degree local adjustment of that need, is established not by the application of norms, but by analysis of statistical data. There is, however, no immediate prospect of sufficient data being generally available to permit introduction of electronic data processing techniques for assessment of need except for certain individual projects in areas where the necessary basic studies have been made. In time, however, the available isolated instances of area social surveys relative to medical need, record linkage studies, hospital simulation exercises and hospital activity analyses can be expected to develop to a point at which it will be possible to apply electronic data processing techniques to assessment of functional content of hospitals. Thereafter, it should be possible to extend the use of the analytical method. For the time being, need will usually be assessed mainly by the empirical method, statistical analysis being used to check and support the results to the extent that the data available permits.

Adjustment Factors

21 The steps which need to be taken in considering local adjustment to gross primary need may be summarised as follows:

22 **Assessment of gross primary need (treatment).** Ideally this would be a continuous function at Regional level, using either or both of the methods described above, and involving sample social surveys to discover the actual extent of morbidity. It would best be achieved on a combined service basis by the parts of the National Health Service.

23 **Assessment of allied medical services.** This may be presented under the following sub-heads:

Intra-regional hospital services
Inter „ „ „
Teaching „ „ „
Local Authority „ „
General Practitioner „

This stage is currently undertaken in large measure for recurrent reviews of the ten year plan. There is, however, opportunity for closer integration of the hospital and local authority services in the planning stages, particularly in relation to provision of psychiatric, geriatric and maternity services.

24 **Determination of net primary need (treatment).** By relating the provision made by allied medical services to the gross primary need, and taking account of the effect of forward-looking planning policies, it is possible to determine a net primary (treatment) need.

25 **Determination of secondary need.** Secondary need is defined, in this context, as that which is raised by having to make provision, other than in clinical building and equipment, to meet the primary need. The major elements of secondary need are, therefore, staff requirements and ancillary service requirements.

26 **Statement of primary and secondary functional content** together with statement of planning policies (see H.B.P.N.2).

Presentation of Statement of Functional Content

27 A specimen Summary of Functional Content for a major Regional Hospital Board project is shown in the Appendix (Form F.C. [R]). It consists essentially of a list of the various departments which together constitute a hospital, alongside which are columns for the various stages of calculation of proposed functional content.

28 *Column 1* List of departments.

Column 2 List of relevant functional units.

Column 3 List of norms used.
(It is emphasised that the norms (whether national or Board—see paragraph 18) represent averages and will not usually be applicable individually to every project, hence potential differences between columns 6 and 7).

Column 4 Gross need. Calculated for the *Group* by relating the norm to the population to be served.

Column 5 Existing Hospital Services: divided into two columns:

(a) Facilities to be retained.

(b) Facilities to be abolished.

Column 6 Net need. Calculated by relating column 5 to column 4.

Column 7 Proposed project content. Determined by relating column 6 to other proposed hospital projects, allied services (L.H.A. and G.P.), specific local factors, and planning policies (see H.B.P.N.2).

Column 8 Notional departmental areas as derived from Departmental Cost Guide and Notes for Guidance (H.B.P.N.6).

Column 9 Departmental costs as derived from Departmental Cost Guide. (See also H.B.P.N.6).

29 For minor projects involving the addition or replacement of single departments the same principles apply.

APPENDIX

Form F.C. (R)

Region
H.M.C.
Hospital
Planning Population (H.M.C.)

Statement of Functional Content

1 Department	2 F.U.	3 Norm of provision	4 Gross Need	5 Existing Facilities:		6 Net Need	7 Proposed content	8 Notional Departmental areas	9 D.C.G. Cost
				To be Retained	To be Abolished				

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